Tier 3 Divestment:

Principles to Guide the Transfer of Non-Bedded Services from Former Provincial Psychiatric Hospitals to Community Mental Health Agencies in Ontario

Mental Health Programs, Mental Health and Addiction Branch

September, 2006

Ontario

2007-00386

Table of Contents

4 **Endorsement**

5 **Mental Health Reform in Ontario: The Context for Tier 3 Divestment**

6 **The Need for a Tier 3 Provincial Working Group**

7 **Making the Working Group Work: How the Group Functioned**
7 Establish a Collaborative Outlook
7 Communications
7 Bring Issues to the Table: The Debate Over "Community"
8 Brainstorming Sessions

9 **A Framework for All**
9 Defining Non-Bedded as a Program Type
9 Examples of Non-Bedded Services
10 Assumptions Made in Developing the Definition of Non-Bedded
10 Common Features Among Non-Bedded Programs
11 Benefits of Divestment
11 Benefits of Divestment for Sending Organizations
11 Benefits of Divestment for Receiving Organizations
12 Summary of Benefits
12 Barriers to Divestment
13 Barriers to Divestment for Sending Organizations
13 Barriers to Divestment for Receiving Organizations
13 Summary of Barriers

14 **Vision**

14 **Principles**

15 **Guiding Principles**
15 Individual-Focused Philosophy of Care
15 Integration
16 Evolution of the Mental Health System
16 Flexibility
17 Emerging Needs
17 Maintain or Enhance Services
17 Records and Information Sharing
18 Monitoring and Evaluation
18 Human Resources: Disclosure
18 Human Resources: Transfer
19 Human Resources: One Move
19 Continuing Education and Training
19 Divestment Costs

20 **Process Principles**
20 Communications
20 Planning (Process, Content, and Implementation)
21 Sharing and Learning About Tier 3 Transfer
21 Support of Government Ministries

22 **Criteria**

25 **Moving Forward**

26 **List of Contributors**
29 Special thanks
30 Alternates

31 **References**

32 **Appendix**
32 Glossary of Terms

Mr. Ron Sapsford
Deputy Minister
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor St.
Toronto, Ontario
M7A 1R3

Dear Deputy Sapsford:

On behalf of the Tier 3 Provincial Working Group, I am pleased to submit to you the final report. As you are aware, you established this Working Group in Summer 2005 to provide principles and advice to the Ministry of Health and Long-Term Care regarding the transfer of non-bedded programs previously managed by the provincial psychiatric hospitals to community agencies, as appropriate.

In undertaking its task, the Working Group considered many dimensions of this issue including:

- what programs could be considered as non-bedded programs,
- the factors that might influence hospitals and community agencies to participate in discussions related to divestment of programs,
- principles to guide the transfer of programs,
- process principles to support effective discussions, and finally
- the criteria that parties should consider in determining what programs should be divested.

As the Working Group's discussions evolved, we realized that these principles were not only important for divestment processes but that they may also prove useful to other initiatives. For example, with the Local Health Integrated Networks' emphasis on integration of services, this document may offer some guidance.

It is the Working Group's firm belief that the needs of people with serious mental illness, particularly in relation to continuity of care, should be uppermost in the minds of hospitals and community agencies as they initiate and pursue discussions about the transfer of non-bedded programs.

Respectfully submitted,

Carrie Hayward
Chair
Tier 3 Provincial Working Group

Endorsement

Members of the Tier 3 Provincial Working Group have endorsed this report with their support and approval.

Nancy Cornwell
Program Manager, Mental Health Lead
North Regional Office, MOHLTC

Robert C. Cunningham
President and Chief Executive Officer
North East Mental Health Centre, North Bay/Sudbury

Winnie Doyle
Integrated Vice President of Mental Health and Addictions Program
St. Joseph's Healthcare, Hamilton

Pamela Hines
Chief Executive Officer
Canadian Mental Health Association
Windsor-Essex County Branch

Cliff Nordal
President and Chief Executive Officer
St. Joseph's Healthcare, London

Don Palmer
Executive Director
Causeway Work Centre, Ottawa

Judy Shanks
Chief Executive Officer
Canadian Mental Health Association
Cochrane-Timiskaming Branch

Bruce H. Swan
President and Chief Executive Officer
Royal Ottawa Health Care Group

Brent Woodford
Executive Director
Adult Mental Health Services of Haldimand-Norfolk

Mental Health Reform in Ontario: The Context for Tier 3 Divestment

One of the biggest changes during the course of mental health reform in Ontario has been the divestment (transfer) of governance, programs and services from the former Provincial Psychiatric Hospitals (PPH) to public hospitals.

In 1996, the Ministry of Health and Long-Term Care (MOHLTC) established the Health Services Restructuring Commission (HSRC) as an independent body with a four-year mandate to:

- Make decisions on restructuring Ontario's public hospitals, and
- Make recommendations to the Minister of Health and Long-Term Care on reinvestments in and restructuring of other parts of the health system and other changes required to support restructuring generally, and to improve the health services system in the province.

In discharging this mandate, the HSRC recommended to the Minister of Health and Long-Term Care the divestment of Ontario's 10 PPHs to the public hospital system. Since 1998, the MOHLTC has transferred governance and operations of nine PPHs to public hospital boards. One PPH still remains to be transferred. The transfer of governance and operations was known as Tier 1 of the divestment process. Tier 2 involves the subsequent transfer of psychiatric beds and associated services by the Tier 1 receiving public hospital to other public hospitals, as directed by the HSRC.

The rationale for transferring programs and services from PPHs to public hospitals and community mental health agencies has always been to meet the needs of individuals with serious mental illness in the most appropriate and least restrictive setting(s). The divestment of PPHs has been an important step towards the ongoing goal of mental health reform; creating an efficient, co-ordinated, and integrated community-based system of care.

In terms of sequencing, Tier 1 divestment must happen before Tiers 2 and 3 can take place, but Tiers 2 and 3 are not necessarily sequential processes. Tier 2 divestment is not a mandatory requirement or a prerequisite to the process of Tier 3 transfer. Many Tier 2 receiving hospitals have not yet completed Tier 2 divestment, however, the ministry is now preparing for Tier 3, which refers specifically to the transfer of non-bedded programs and services from Tier 1 and 2 receiving hospitals to community mental health agencies, where appropriate. "Non-bedded" programs are mental health services that can be provided to individuals in their own environment (e.g., home, workplace, etc.) and do not require an overnight stay for medical care.[1]

[1] The definition of non-bedded programs specific to Tier 3 divestment is described in greater detail on page 10 of this report.

The Need for a Tier 3 Provincial Working Group

In the summer of 2005, several Tier 1 and 2 receiving hospitals commenced their own discussions about the next phase in PPH divestment. Correspondence from these hospitals to the MOHLTC emphasized the importance of provincial direction for all affected parties prior to any Tier 3 transfer being implemented.

While there were explicit directives governing Tiers 1 and 2 divestment from the HSRC and the Health Reform Implementation Team of the MOHLTC, there were none governing Tier 3 transfers. The Deputy Minister of Health and Long-Term Care recognized the value of assembling a working group at the provincial level that could begin to formulate a cohesive set of principles that would establish guidelines for Tier 3 divestment.

The group would be small and comprise key individuals who were familiar with program transfers, hospital divestment, and mental health service delivery, from both hospital and community-based settings, affected by PPH divestment.

In August 2005, the Director of the Mental Health and Addictions Branch of the MOHLTC invited four representatives from divested hospitals and four representatives from the community mental health sector to participate in this working group with ministry staff. The group was envisioned as a constructive forum in which to develop principles that would provide direction to the transfer process and share advice on common systemic, clinical, programmatic, and funding matters associated with Tier 3 divestment of non-bedded programs to the community.

The Tier 3 Provincial Working Group convened its first meeting in the Fall of 2005 with a mandate to develop common principles that could be applied provincially to set a foundation for further discussions at regional and local levels, when divestment of non-bedded programs becomes appropriate.[2]

In its first meeting, the working group confirmed its objectives to:

- Develop principles that will guide the process of Tier 3 transfer;
- Provide advice on issues of implementation; and
- Construct a working definition of non-bedded programs and services that would be specific to the Tier 3 process.

Meetings were held once per month in Toronto from October 2005 until March 2006. Members of the group attended meetings either personally or by telephone, when necessary, to maintain continuity in discussions and group composition.

[2] Use of the term "regional" throughout this report denotes a geographic area in which transfers may occur.

Making the Working Group *Work*: How the Group Functioned

Establish a Collaborative Outlook

In its first meeting, the Tier 3 Provincial Working Group engaged in an exercise where they shared their own expectations of participating in the group. Some of their expectations included:

- Clarifying provincial directions pertaining to principles of divestment, understanding that flexibility will be required to meet the needs in different communities and regions;
- Working toward a mental health system that includes both hospitals and community agencies;
- Focusing on fostering integration of the whole mental health system, regardless of where non-bedded programs and services are located or who administers them;
- Understanding that, if the group endorses the recovery model of care and treatment, then 'ownership' of non-bedded services is secondary to evidence-based practice and outcomes for clients; and
- Facilitating the divestment process for local parties.

From this roundtable discussion, the group established a collaborative outlook that was based on the mutual goal of mental health service integration with minimal service disruption in order to optimize the best outcomes for clients, consumers and families.

Communications

The Tier 3 Provincial Working Group spent considerable time discussing the topic of internal and external communications. The group paid particular attention to the interest in its mandate and objectives from others (i.e., provincial associations and union groups representing personnel that would be affected by Tier 3 transfers) who were not invited to participate, and had expressed their concerns in writing to the ministry.

Group members acknowledged that they might not have the required expertise, at times, to inform their work. They established a proviso to invite external guests who could provide pertinent clinical expertise in the event that additional information was needed.

The first meeting also involved discussions about how to mediate the considerable interest from other parties in the working group's mandate and simultaneously, address the desire to be transparent and responsive.

Provincial Working Group members explored the idea of using a website or ListServ to enable interested parties to learn more about the group's work as it proceeded. This desire for transparency eventually resulted in the Tier 3 Provincial Working Group section on the MOHLTC's public website.[3]

Bring Issues to the Table: The Debate Over "Community"

Meetings of the Provincial Working Group brought together several viewpoints about mental health service delivery from acute care and specialty hospitals and community agency environments. With its emphasis on shifting services from institutional settings to community settings, the foundational groundwork of mental health reform provided an impetus for the working group to discuss the different ways in which the term "community" is conceptualized.

[3] http://www.health.gov.on.ca/english/providers/program/mentalhealth/mohtier3.html

"Community" is typically defined in one of two ways: operationally, according to funding relationships between programs and their administrative sponsors, or geographically, according to where programs are situated. Nuances associated with different work environments helped to clarify how comparable programs may vary in their delivery or service expectations, depending on the setting in which they are offered.

For instance, acute care hospitals and academic health science centres are places that are expected to be accessible 24 hours a day, seven days per week, offering emergency medical services, surgical, obstetric, inpatient and outpatient care. Consequently, they are necessary components of the health care system where sick or injured people can obtain treatment or surgical intervention for illness and/or disease for a discrete period of time. Some hospitals also offer community-based programs that are funded through the community mental health funding envelope and these programs can be located within hospitals or community settings.

Community mental health agencies offer a range of services and supports that are complementary to hospital inpatient services. Community agency services help to reduce the frequency of hospital admissions and the length of stay at psychiatric facilities, aim to support people in their home communities and also focus on health determinants such as housing and vocational opportunities.

Both groups may claim the community as their working environment, yet there remains much philosophical debate over "community" as something beyond physical location and/or funding source. For the purpose of this report, both groups recognized their complementary roles as necessary and equal components of an integrated health system and healthy community.

The Tier 3 Provincial Working Group comprised equal representation from both hospital and community agency settings. Despite their seemingly disparate work environments, the group was united by a single purpose: to support the provision of appropriate service(s) to individuals with mental illness and their families at the right time, in the most appropriate setting, by the most appropriate provider(s).[4]

Brainstorming Sessions

Brainstorming sessions began at the first meeting and proved to be a productive exercise for the group. The uninhibited dynamic allowed large volumes of work to be undertaken with a collaborative spirit.

In its first meeting, the working group spent time drafting an initial list of programs and services that could be considered non-bedded.[5] This was an important first step in the development of guiding principles for Tier 3 divestment because it established an initial understanding of the many services that are delivered in both hospital and community agency settings. It also clarified similarities between programs and pragmatic, mutually beneficial relationships that many non-bedded programs have with their administrative sponsors. Brainstorming these ideas led to discussions about determining whether certain shared characteristics constituted eligibility for programs to transfer from hospitals to community agencies, or whether inherent differences in their service functions suited one environment over another.

The initial brainstorming session also identified potential barriers to divestment from both community agency and divested hospital perspectives. In order to understand the potential barriers to Tier 3 transfer, the group discussed the possible factors that might discourage a community program from wanting to assume responsibility for a program previously sponsored by a hospital. Conversely, the group also discussed the reasons why a hospital might not want to transfer a non-bedded program to community sponsorship. The common features and disparities among non-bedded programs, as well as the benefits and barriers of transferring them from hospitals to community agencies, are described in the following section.

[4] See page 14 for "Vision" section

[5] See page 9 for examples of non-bedded services.

A Framework for All

In Ontario, mental health policy and program planning has shifted its emphasis from treating people with mental illness in institutions to supporting their recovery efforts through effective and accessible services delivered outside hospital walls, in the community.

Strategic investments made over the past three years have increased capacity in the community sector to provide mental health services in key areas such as Assertive Community Treatment (ACT), crisis response, intensive case management and early intervention in psychosis.[6] Additional investments have also targeted services and supports to help divert persons with mental illness from the criminal justice and correctional systems toward more appropriate community-based mental health care when they have committed low-risk offences. All of the service types that have received increased funding in recent years are considered to be non-bedded programs.

Defining Non-Bedded as a Program Type

Since non-bedded services were referenced in the definition of Tier 3, then the Provincial Working Group needed to define what constituted a non-bedded program.

In order to do this, the group engaged in a preliminary exercise to identify examples of programs that are currently based in hospitals, which could be considered non-bedded. These are programs that are already offered by community agencies in Ontario albeit, not in every region. This exercise did not result in an exhaustive list of all non-bedded programs, rather, a preparatory understanding of those programs most commonly understood as such.

Examples of Non-Bedded Services

This list is not comprehensive or exhaustive. It represents examples of non-bedded mental health services that are currently provided by many community mental health agencies and hospitals. No recommendations have been made regarding governance of these programs or their transfer as part of Tier 3 divestment.

- Vocational employment
- Family therapy
- Assertive Community Treatment (ACT) teams
- Social/recreation programs
- Transitional discharge programs
- Supportive housing
- Step-down beds
- Crisis beds
- Counselling/therapy
- Court diversion
- Family education and support
- Case management
- Co-ordinating Community Treatment Orders
- Early Intervention in Psychosis programs
- Community support
- Crisis services
- Mental health clinics
- Peer support
- Day programming, such as counselling in a supervised environment
- Health promotion: lifestyle counselling to address co-morbid conditions
- Public education
- Concurrent disorders programs
- Psycho-Social Rehabilitation
- Psycho-geriatric outreach and consultation to Long-Term Care Homes
- Wellness clinics
- Eating disorder day programs
- Self-help groups
- Forensic outreach to correctional centres
- Suicide prevention
- Skills development such as life skills, pre-employment
- Client education
- Addictions programs
- Dual diagnosis programs
- Homeless outreach
- Information, assessments and referrals

[6] The 2003 First Ministers' Accord on Health Care Renewal (Accord funding) provides targeted federal funding through the Health Reform Fund of $16B over five years for primary health care, home care and catastrophic drug coverage. Accord funding will provide $117M in community mental health services for four years, 2004-05 through 2007-08.

Assumptions Made in Developing the Definition of Non-Bedded

Once the group had a working list of programs with which to use as their foundation, they made the following assumptions about mental health service delivery within the context of the current health care climate in order to develop their final definition. These assumptions should be understood collectively:

- The issue of service governance was not a factor in developing this definition.
- Whatever organization sponsors a service, all services, whether tertiary, acute or community-based, require linkages and protocols to facilitate integration and seamless services.
- The present system, which includes services (both acute and tertiary) that are located in community and hospital settings, work differently by providing an array of services that form an integrated system serving the individual, client, consumer and family.
- Services should be mobile, supplementing, not supplanting the providers with whom the individual is familiar. (Community providers follow the client into hospital to provide integrated care and where appropriate, both community providers and specialized services follow the person to the community).
- Hospitalization should be a last resort because it is a disruption in people's lives.

The group reached consensus on the following definition of non-bedded programs:

> Non-bedded mental health programs and services are those which can be provided in the individual's home environment (e.g., home, workplace) and do not require an overnight stay for medical care.

This definition does not include clinical interventions that are required for inpatient services.

As the working group drafted its list of non-bedded programs, it became apparent that many are presently delivered in both hospitals and community agency settings, although their availability is not standardized in all community agencies throughout the province. Consequently, the short list of programs required an appreciation of their common features.

Common Features Among Non-Bedded Programs

All non-bedded programs are capable of being delivered outside of hospitals, as they are fairly uncomplicated insofar as not necessitating expensive equipment or technology compared to the non-mental health acute and tertiary care systems. They require mostly human resources and employ frontline providers with similar skill sets and comparable academic and training backgrounds (e.g., social workers, nurses, occupational therapists, etc.). While non-bedded programs are significantly less costly to operate than bedded programs, their positive impact on serving the needs of individuals with serious mental illness cannot be under-estimated or overlooked. Most of these programs endorse a recovery-oriented focus and enjoy elements of flexibility and diversity in their design and delivery by not being fixed to one location or set constellation of services. This flexibility enables the programs to be more responsive to individual needs versus institutional needs.[7]

Many non-bedded programs depend on mutually beneficial relationships between hospitals and community mental health agencies. These programs readily make use of multiple bridging points to other types of services and supports so that individuals can access various parts of the mental health, primary care or acute care systems during alternating stages of illness and wellness. While most are transitional programs that lead to other components of the mental health and general health care systems, some programs, like Assertive Community Treatment teams, are long-term services that require inter-organizational linkages in order to maintain continuity of care for clients. Non-bedded programs also serve as a foundation for many students, interns, and residents for receiving clinical education credits.

[7] The group was careful to note that they were not making generalizations about hospitals and community agencies and they recognized that many hospital-based non-bedded programs are extremely client-focused, innovative and cost-effective.

When clients are involved in several programs simultaneously, there is greater chance for service duplication and reduced integration and co-ordination within the mental health service sector. For that reason, non-bedded programs may require formal relationships, processes and protocols with primary, acute and tertiary care partners to ensure continuity of care for clients.

Benefits of Divestment

Service overlap and ambiguity in functional expectations are realities shared by acute care hospitals and community mental health agencies when they both provide non-bedded programs. There are mutual benefits to Tier 3 divestment for both sending and receiving organizations.

The transfer of non-bedded programs from hospitals to community agencies supports the main thrust of mental health reform by investing in community-sponsored care that enables individuals with serious mental illness to live more independently in their home environment, rather than in a hospital. Hospital-sponsored non-bedded programs also support independent living in a community environment; the benefit of transferring non-bedded programs from hospital to community agency sponsorship is the possibility for improved integration and co-ordination among complementary mental health service providers across the health care system.

Benefits of Divestment for Sending Organizations

The provision of non-bedded services such as public education, homelessness outreach and supportive housing may be incongruent with the specialized care and short-term delivery of acute care in many hospitals. Divestment could allow hospitals to focus on their core business, which in many cases, is connected to non-bedded services to ensure continuity of care.

Community mental health programs sponsored by hospitals are funded on an extra-global or separate vote basis. Community mental health programs have not benefited from the same increases to base budgets as hospitals. Over time, the funding for these services erodes, or results in program deficits. Maintaining these programs at their original service level and staff complement requires additional investment by the sponsoring hospital from their global budget, or other sources.

Frequently, hospitals comprise multiple campuses and some of the non-bedded services of a hospital may be delivered far from its main campus site. From an organizational perspective, divesting programs to local community agencies could enhance a hospital's efficiency.

Firm hospital policies may hinder the delivery of non-bedded services by being too restrictive. Programs that require more latitude in their application in order to be effective, such as vocational services, may be better delivered by community agencies that have greater flexibility and specialized capacity in their program design and implementation.

Similarly, there are numerous incentives for community agencies to receive non-bedded programs from divested hospitals.

Benefits of Divestment for Receiving Organizations

There is desire and readiness among community mental health agencies to broaden their continuum of services. Community agencies already have significant experience in the provision of non-bedded services. By accepting additional programs, they will likely expand their existing service spectrum. Increasing the quantity and variety of services that agencies provide will help to build critical mass and create opportunities for greater specialization of mental health services in the community sector. Receiving non-bedded programs could also create synergies with other allied mental health services to reduce competition for resources.

Accepting divested programs may lend greater flexibility to community mental health services and allow them to be even more responsive to individual needs by being creative with their staffing mix and mode of delivery. This responsiveness is demonstrated by the many empowering opportunities offered by community agencies for consumers to play an active role in organizational governance, program planning and design. Likewise, the potential for program innovation could expand service capacity and help to promote community mental health service provision as an attractive career option.

Taking on divested hospital programs would increase the scope, raise the significance and likely change the perception of mental health services that are delivered by community agencies. Transferring non-bedded programs to mental health agencies encourages a shift in public and professional perception towards accepting and appreciating community agencies, particularly when many of these non-bedded programs are already delivered by community agencies in other parts of the province. This could also help to address broader wage harmonization issues within the mental health service sector.

The social stigma affiliated with seeking help for mental illness possibly could be reduced by Tier 3 divestment, since programs offered by community agencies are more publicly visible than those offered inside hospital walls. Non-hospital service sites may facilitate individuals' recovery efforts by being located in community agency environments, which are often perceived to be more normalized and less illness-focused.

Receiving divested programs may facilitate the evolution of local relationships between hospitals and community agencies and therefore, enhance community capacity overall. Increased capacity in the community mental health sector promotes the need for continued professional development, which could take the form of shared educational and training opportunities between hospital and community providers.

Summary of Benefits

Tier 3 divestment has the potential to help clarify roles and service expectations for sending and receiving organizations. For hospitals, divestment affords the opportunity to focus scarce resources on specialized treatment interventions for sick and injured individuals. Divestment of non-bedded programs also encourages hospitals to foster relationships with their local community agencies, which can serve to improve the integration of mental health services across the health care system.

Likewise, the transfer of non-bedded programs offers possibilities for capacity-building in the community mental health sector by broadening its operational scope, improving public perception of mental health service delivery outside the hospital environment, while fostering collaboration and integration with hospital partners for increased learning and training opportunities for program staff.

Tier 3 divestment supports the provincial vision of mental health reform as an integrated and co-ordinated system of care, while establishing clear roles and expectations for hospital and community mental health agency environments.

Nonetheless, the issue of Tier 3 transfer raises concerns for both sending and receiving organizations. The following section presents anxieties held by both groups with respect to divesting and accepting non-bedded programs.

Barriers to Divestment

Just as hospitals may perceive numerous advantages to transferring non-bedded programs to community agencies, there is also logic behind the motivation to maintain these programs with hospital sponsors. By the same token, community agencies have their reasons to be hesitant about considering the responsibilities of receiving divested programs from hospitals. The following points provide arguments against Tier 3 divestment from both hospital and community agency perspectives.

Barriers to Divestment for Sending Organizations

Particular programs may be integral to the existing specialized care offered by hospital on an outpatient basis and may disrupt the integrity of client care if divested. Similarly, key program staff (e.g., psychiatrists) may not want to leave a hospital program that offers inpatient and community-based elements and there may be a loss of critical mass to departments, once programs divest.

During this time of transformation across the health care landscape, if operating dollars for community mental health programs were to be frozen, then there could be a loss of future capacity in that sector and services could erode, rendering hospitals responsible for providing care.

Not all community providers can deliver services equally and they may not deliver services in the same way that hospitals can. For instance, there is a perceived lack of confidence in timely pick-up by community agencies with respect to effective discharge planning, which enables a hospital's ability to be efficient. There is concern that community providers may lack the capacity to deliver clinical programs as they are and may not be ready to receive them.

If non-bedded programs were to transfer out of hospitals, then a loss of diagnostic efficiency could result. Some individuals may have to travel to multiple service sites in order to receive assessments. Similarly, with a physical transfer of programs, staff may need to travel to multiple sites in order to provide care and this could prompt a loss of operational efficiency. A change in program administration could also bring about a possible loss of accredited sites (and clients) for academic training purposes.

Barriers to Divestment for Receiving Organizations

The potential expense associated with Tier 3 divestment is likely the chief barrier for many community agencies. Agencies will likely incur costs over and above any funds that are transferred with a program, such as inheriting a deficit along with the program that the agency cannot manage. In addition, community agencies require guarantees to ensure that their services will be safeguarded with annualized increases to keep pace with inflation and other cost drivers. Smaller agencies may be unable to administratively support divested programs because they simply do not have the same infrastructure as most hospitals. As receiving organizations for staff who used to be employed in hospital environments, some community agencies may not be able to manage long-term salary expectations or differential (pay equity) issues. Any inability to recruit qualified staff will have ramifications on the community's ability to deliver programs effectively. Tier 3 transfers may also lead to agencies becoming unionized environments, which for some would represent a significant change.

Aside from expenses, programs received from hospitals may be inconsistent with an agency's model of care, philosophy or culture, and they may not be adaptable. Conversely, some agencies may not have previous expertise with certain types of programs and they may not be prepared to develop in-house expertise.

Receiving non-bedded programs from hospitals may encourage an over-reliance on academic health science centres and their programs. Similarly, other affiliated program requirements (e.g., Ontario Review Board hearings) may be too onerous for some agencies to manage.

Lastly, the stigma that may exist among the general public or even from within the receiving agency about the severity of mental illness in clients who originally came from hospital-based programs may hamper an agency's capacity to maintain effective programming.

Summary of Barriers

Both sending and receiving organizations have concerns regarding Tier 3 divestment. There are paradigm shifts that need to take place in order to foster trust in the community sector's ability to provide comparable, effective, clinical care to individuals with serious mental illness.

From the community sector's perspective, cost is a major concern when it comes to considering a Tier 3 transfer of programs from hospitals. While there is clinical readiness and desire to expand and enhance the community mental health service system, agencies have not enjoyed the same type or extent of stable funding as hospitals, and have realistic concerns about taking on additional program responsibilities with a history of scarce resources.

While both sectors have reservations about Tier 3 divestment, there is a common acceptance of mental health reform shifting the balance of service delivery from hospitals to community settings. Effective communication and planning will be paramount to a successful program transfer and to ensuring consistency in Tier 3 negotiations across the province. Interested parties that are considering Tier 3 divestment will have to engage one another in critical dialogue to plan this process strategically, appropriately and thoroughly. They will need to consider the parameters and interests of all involved parties, which includes affected clients and their families, in order to assess the benefits and implications of all viable transfer options.

With the transformation of Ontario's health care system no longer on the distant horizon, Tier 3 divestment becomes a distinct possibility for many organizations and thus, requires a mutually shared vision for the process.

Vision

The Ontario government has committed to the key priority of delivering better health care. In order to achieve this goal, fundamental changes to the health care system are underway to create a system that is client-focused, results-driven, integrated and sustainable. Transformation in the province's health care system affords the opportunity to do things differently.

Throughout its mandate, the working group developed guiding principles for Tier 3 divestment based on shared values that placed the health and wellbeing of individuals at the forefront of their discussions. The group believed in the potential of an integrated health care system that builds on evidence-based practice and addresses all determinants of population health. Such a health care system would foster and preserve collaborative partnerships, respect individual autonomy and recognize the capacity for people to flourish in times of illness or wellness when they receive appropriate care and support.

With the most significant influences to population health being income, housing and employment supports, the working group drafted their vision of Tier 3 divestment as:

> People with mental illness will receive services that meet their individual needs, delivered by the most appropriate provider or team of providers, in the least intrusive and most normalized setting, given their particular circumstances.

This vision entails an understanding of an integrated system that works collaboratively to support the population with serious mental illness who benefit from community-based care by focusing on the most appropriate location and delivery method of services, rather than ownership or administration of services.

Principles

By its second meeting, the Tier 3 Provincial Working Group began to consider a wide variety of preliminary principles to guide the divestment process and also identified the need to establish criteria that could provide direction regarding what programs and services should transfer.[8]

[8] See page 22 for a detailed explanation of divestment criteria recommended by the working group.

As the discussion of possible principles for divestment unfolded, the group recognized the need for two categories of principles: guiding principles to direct the transfer of programs, and process principles to support effective Tier 3 divestment discussions among regional and local planning partners.

Guiding Principles

Guiding principles are the over-arching values and beliefs that establish how divested programs should transfer and enhance the mental health service system, outline key components and provide a contextual foundation to assist in achieving the overall vision. The following guiding principles are arranged in order of their significance.

Individual-Focused Philosophy of Care

> Continue to support programs and services that focus on an individual's recovery and wellness, with respect for each person's right to participate in his/her community and to reach his or her full potential.

Endorsing an individual or client-focused philosophy of care is an important first principle because it recognizes that people with mental illness prefer to focus on their wellness rather than their illness. This principle entails an understanding of individuals with mental illness as persons first, rather than as a set of pathological behaviours or diagnoses.

An individual-focused philosophy of care also considers a broader view of health that identifies health promotion, health determinants and relationships of clients and their families as necessary elements to sustaining wellness in recovery.

Integration

> Achieving integration involves bringing together services, providers and organizations from across the continuum to work together so that their services are complementary to one another, are co-ordinated with each other, and are a seamless, unified system with continuity for the individual.[9]

Integration focuses on the importance of an individual's continuity of care, which should not be determined or affected by program funding source(s) or administrative sponsorship.

Tier 3 divestment is well suited to an alignment with other system planning and integration efforts, such as establishing provincial program standards and common remuneration practices. Opportunities to make use of technology in order to promote efficiency are also required.

Integration involves the clustering and co-ordination of services across the existing mental health service system by adopting a "zero exclusion" policy, whereby criteria would not be used to exclude individuals from participating in programs. Exclusion criteria act as barriers to integration, shared care and enhanced system capacity.

[9] This definition of integration is adapted from the Canadian Council on Health Services Accreditation, *Achieving Improved Measurement Standards*, Second Edition, 2002.

Evolution of the Mental Health System

The divestment process should be built on and informed by previous policies, consultations and planning initiatives, recognizing and responding to the evolving mental health system.

Mental health reform is an evolutionary process that is based on a history of effort involving numerous consultations, evaluations, accountability frameworks, special reports, policy frameworks, implementation plans and strategic initiatives. Planning for Tier 3 divestment would benefit from the previous work that has helped to change the course of mental health service delivery and design, but must also recognize that the system is not static.[10] For example, these historic documents did not envision the development of Local Health Integration Networks when they were prepared. Since the mental health system is dynamic, then it must evolve in response to changing population needs as well as conceptual, clinical and technological advances.

Flexibility

Decisions regarding the transfer of services must balance evidence-based practices and standardized approaches that strengthen service delivery, system performance and resource utilization with the flexibility required to meet the dynamic and unique individual and local needs that enable optimal outcomes.

Following the assertion that the mental health care system is constantly evolving, the principle of flexibility addresses the need for service providers to recognize and adapt their programming to the unique needs of each person and each community.

The vision of Tier 3 divestment as, "people with mental illness receiving services that meet their individual needs, delivered by the most appropriate provider or team of providers, in the least intrusive and most normalized setting, given their particular circumstances," acknowledges the flexibility involved in matching services with needs according to a person's degree of illness and/or wellness.

This principle suggests that issues of governance are of secondary importance in the process of Tier 3 divestment because it is critical to support individuals in the least intrusive way that maximizes resources and minimizes duplication of services (i.e., provision of intensive case management services vs. Community Treatment Orders). Furthermore, evidence and standards should guide discussions about Tier 3 divestment to the greatest extent possible, but notwithstanding the broader consideration of individual and local needs, and arrangements. The key is to achieve optimal outcomes for clients.

[10] See page 31 for a list of background documents that comprise the historical and current context for mental health reform in Ontario.

Emerging Needs

The mental health system is dynamic and needs to adapt on an ongoing basis to changing needs. Stakeholder engagement will inform negotiations regarding service transformation and service protocols to preserve and enhance continuity of care, service efficiency and inter-organizational accountability with the goal being to ensure evidence-based practice and accepted standards.[11]

In a dynamic system, program design and delivery will change in accordance with the needs of the client population. This principle raises the concern for being conscious and responsive to shifts in client needs, community needs and service transformation through evidence-based practices, in addition to being accountable for service changes that affect clients and other stakeholders.

Service transformation in the mental health sector obliges providers to collaborate, negotiate and come to agreements about whether programs will change, and to clarify how they will change as a result of Tier 3 divestment, in order to mitigate service disruption and continuity of care for clients.

As community agencies receive divested programs, service protocols may be of greater importance, particularly as they relate to discharge planning and re-admission procedures.

Maintain or Enhance Services

All transfers will maintain or enhance existing service capacity and/or quality.

Tier 3 divestment is intended to maintain or improve the delivery of mental health services through better integration and co-ordination within the existing system. Its aim is to improve the system's effectiveness by investing in community-based care and increasing its capacity to serve clients in their home environment.

Tier 3 divestment is not an attempt to scale down organizations in an effort to make the mental health system more cost-efficient and accountable.

Records and Information Sharing

Recognizing the requirements of PHIPA: Sending organizations will transfer copies of health and other required/relevant records and/or program information to ensure continuity of care as well as seamless transition of programs to the receiving organizations. Protocols must be established to share information between organizations on an ongoing basis to provide linkages for uninterrupted continuity of care

Legislation in Ontario requires that all health custodians with access to a client's personal health file must comply with the responsibilities put forth in the Personal Health Information Protection Act (PHIPA). The Act establishes a comprehensive set of rules about the manner in which personal health information may be collected, used, or disclosed across Ontario's health care system. This principle stipulates that any transfer of programs from hospitals to community agencies must set up an information-sharing protocol that does not expire once a program transfers, in order to account for clients who move from one environment to the other during alternating stages of illness and wellness.

[11] Stakeholders include and are not limited to: clients/consumers, families, organizations delivering mental health and addiction services, health providers and can include others such as police officers or other ministries (e.g., MCSS), depending upon the clients' needs and the program focus.

Monitoring and Evaluation

Evaluation is essential to the transfer process. Assessing the impact of service transfer should be multi-dimensional and include the individual and family, service provider and system dimensions, as well as any impacts on research, and education of health providers.

Evaluation is a crucial element of program design and system maintenance to determine whether changes made at the micro or macro level achieve desired outcomes and/or result in impacts to other parts of the system, and to make necessary adjustments. With Local Health Integration Networks (LHINs) assuming a key role in planning health services, it will be essential to engage all involved and affected parties in the evaluation of program transfers to determine whether objectives were met and whether additional strategies are required.

Human Resources: Disclosure

In advance of any service transfer negotiation, sending and potential receiving organizations will disclose fully the composition of their human resources and their labour environment.

While drafting its vision of Tier 3 divestment, the Provincial Working Group drew on the following Overarching Statement of Principle from the *Final Report on the Transfer of District and Local Mental Health & Addictions Program in Northeastern Ontario*:

> "The guiding principles are developed to minimize disruption of the workforce and ensure that patient care needs remain the focus of our outcomes. The process will be as transparent as possible. Employees will be regularly informed of the progress of the integration and impact it will have on them. Individuals are valued and will be treated in a fair and equitable manner. Staff input will be sought when possible and local negotiations will adhere to the defined principles."

This principle addresses the human resource concerns that both sending and receiving organizations have with regard to Tier 3 divestment. By insisting upon full disclosure of the labour environment prior to divestment negotiations, potential receiving organizations can make fully informed decisions based on realistic expectations and an appreciation of the current situation. Applicable legislation and labour agreements will also guide Tier 3 transfers.

Human Resources: Transfer

Program transfer is the preferred approach to human resource transfer in order to enhance consistency with other principles, minimize disruption and preserve program integrity.

Human resources are the most valuable assets to any organization. Consistency in relationships between individuals receiving care and their service providers is vital to maintain. When staff feel anxious about their job security due to a change in structure or administration, such as Tier 3 transfer, then client care has the potential to become inadvertently compromised.

The objectives of Tier 3 divestment are to preserve existing capacity and build new capacity in the mental health care system. For programs under negotiation for transfer to community agencies, this principle suggests that staff in sending organizations be encouraged to follow their work whenever possible, while also being apprised of their options with respect to transfer (e.g., reassignment, severance, early retirement, etc.). Program transfers would maintain program staff and preserve continuity of care and service.

Human Resources: One Move

Every region involved in a Tier 3 transfer will develop a succinct and efficient service transfer plan which includes a labour adjustment strategy with a defined timeframe that minimizes disruption to the continuity of service and facilitates staff transitions to avoid multiple moves.

For a smooth transfer of non-bedded programs to a new physical location, the ideal is to aim for one move rather than multiple moves, wherever possible. For example, an ideal transition would be for a program to transfer directly from hospital-to-community agency rather than hospital-to-hospital-to-community agency. Such an approach minimizes system upheaval, staff uncertainty and costs. This principle outlines the expectation that both sending and receiving organizations will collaborate to develop a mutually beneficial service transfer plan that respects the impact a transfer will have on staff and clients.

A "one move" principle requires a timeframe that reflects unionized environments and sequencing of labour-related steps such as employee decisions on rights and entitlements. Specific issues of timing are described more fully in the Process Principles, Planning section.

Continuing Education and Training

Service transfers will promote research, education and training opportunities for current and future practitioners in hospitals and community agency settings to ensure excellence in the provision of care to people who require mental health and/or addictions services.

With human resources as the key assets, it is imperative to maintain and seize new opportunities for the continuing education and training of this valuable workforce. This principle requires sending and receiving organizations to build linkages with colleges and universities to provide options for research, training and co-operative placements for all mental health service disciplines.

Divestment Costs

'Costs' comprise direct costs such as salaries, benefits and program operations, and indirect costs such as infrastructure, utilities and management. All Tier 3 transfers will use a consistent approach to determine the funding methodology for program transfers. The methodology will include the pre, post, and transition transfer costs for both sending and receiving organizations.

Costs related to Tier 3 divestment may not be incurred sequentially. Sending and receiving organizations would be well-informed to examine the principles associated with Tier 2 divestment in order to understand how transfers can affect costs other than the initial expense of shifting a program and all its components from one physical space to another.

This principle captures the difference between one-time costs, infrastructure costs that may be less obvious to receiving organizations, and transitional costs, which may be an issue for both sending and receiving organizations. This guiding principle also suggests the adoption of a uniform funding methodology for program transfers across the province.

The Tier 3 Provincial Working Group also identified unique costs that could arise, such as severance payments. Costs associated with severance are not within the existing budgets of sending organizations and therefore, need to be considered as extraordinary costs that merit unique consideration by the MOHLTC in the development of a uniform funding methodology.

Process Principles

Process principles cover the fundamental planning elements and groundwork required during the preparatory and implementation stages of Tier 3 transfers.

Communications

Step one in the divestment process: it is critical to establish a proactive communications plan. Communication should be open, transparent and inclusive to ensure timely, consistent messaging between all stakeholders and to minimize uncertainty for all participants in the process.

A straightforward, written communications strategy is required to ensure consistent and timely messaging about program transfers to all affected parties. Apprising all those involved of the divestment process and its progress, including clients, their families, staff of sending and receiving organizations, and others, can effectively minimize anxiety and ensure a common understanding of the process and emerging directions.

Planning (Process, Content, and Implementation)

Developing a Tier 3 divestment plan, including its parameters, is required. The plan will utilize a map of current services and consider population health needs, capacity and the interests of all parties, outlined in the Criteria section of this report, to assess the benefits and implications of all viable options.

Transfer plans will document how each principle has been addressed and will include a consistent set of content requirements.

Tier 3 divestment planning should include the development of a timeframe with a target implementation-completion date that includes service plan development, stakeholder engagement, negotiation, determination of transfers, approvals, the actual transfer of programs, and the related human resource adjustments.

This planning principle requires that sending and receiving organizations consider existing and future service needs if they are negotiating program transfers. A current inventory of community services allows negotiating parties to consider all viable transfer options, relevant benefits and implications.

Ideally, planning for divestment should be an uninterrupted process with an expeditious time limit (i.e., 12 months). Program transfers need a preparation and implementation time frame that complements the service transfer plan's human resources component. Checking the service transfer plan against these principles will enable negotiating parties to evaluate their approach for comprehensiveness and symmetry with these guidelines.

The process of organizing and developing a well-planned Tier 3 transfer may call for a facilitator to assist sending and receiving organizations in reviewing the criteria for divestment, assessing the benefits and implications of transfer options and finalizing a transfer plan.

Sharing and Learning About Tier 3 Transfer

To optimize outcomes, mechanisms are required for sharing information and resources related to Tier 3 transfers.

Learning from the experiences of others that have already been through the Tiers 2 and 3 process will be indispensable to those who are still in the earlier planning and negotiating stages. Some of the same organizations involved in Tier 3 transfers will have already experienced Tier 2 transfers, and can share valuable knowledge on both processes. Organizations that have experienced difficulties with the transfer process can share their learning to help others avoid similar situations, as well as share achievements resulting from successful planning processes and functional partnerships.

Support of Government Ministries

To enable integration and transfer of Tier 3 services, a process will be in place to address and resolve issues associated with government policies, guidelines and practices that may inhibit integration.

This process principle focuses on the role that government can play and acknowledges that there may be issues that require resolution in order to achieve successful Tier 3 program transfers. The role of government includes the participation and involvement of other ministries as they pertain to the policies and operational responsibilities of mental health and addiction programs. For example, the Ministry of Community and Social Services has the lead responsibility for the Ontario Disability Support Program, which affects many individuals involved in non-bedded programs.

Further discussion is required to determine a receptor site within the MOHLTC that could co-ordinate resolution of policy issues that impede integration. For example, some policies may create barriers to integration (i.e., pay grids for Nurse Practitioners in Community Health Centres may differ from mental health and addiction agency pay rates).

The MOHLTC may need to consider creating standardized guidelines for divested hospitals and receiving agencies, LHINs and other stakeholders to help ensure that all affected parties are supported through the planning process and implementation.

Innovative program delivery models and evidence-based practices require government support with annualized funds. The Tier 3 Provincial Working Group expressed concern that community mental health programs have an ongoing need for base increases and adjustments in order to avoid program erosion. The subject of ongoing base increases for community agency programs signals the need to identify and plan for future costs, and the need to consider these issues in relation to the MOHLTC's business planning cycle.

The working group also noted that wage harmonization between the hospital and community sectors was a longstanding issue. While resolving that matter was beyond the capacity and mandate of the group, pay equity legislation will ideally guide and inform its future discussions. There is concern for the impact of program transfers on the wages of other employees from receiving organizations and thus, that organization's overall fiscal situation. Furthermore, there is concern that a wage harmonization issue could negatively affect the interest of many community organizations to participate in program transfer discussions, or the interest of staff to transfer with their program.

Criteria

In its earliest discussions about the range of non-bedded programs delivered by hospitals and community agencies alike, and the common features that they shared, the Tier 3 Provincial Working Group deliberated over the issue of all non-bedded programs automatically divesting. The question of whether all non-bedded programs can be considered the same since they share so many similar characteristics raised additional questions and issues about staff and funding that are inextricably connected to these programs. This issue led the group to develop the guiding principles on human resources disclosure and transfer, and costs. The working group agreed that all non-bedded programs are not the same. Since each community has its own needs and its own local spectrum of mental health services, then the range of non-bedded programs in a given geographic region cannot be considered appropriate for divestment, collectively.

Since there is potential for non-bedded programs to change in terms of staffing, labour environment and/or geographic location if they were to divest from a hospital environment to a community agency setting, then criteria were developed in order to help determine the elements that make programs eligible for Tier 3 transfer. Programs being considered for transfer do not have to meet every one of the following criteria. All of the criteria, however, must be considered during the preliminary negotiating and planning phases of Tier 3 divestment in order to decide the suitability of transferring a non-bedded program from a hospital to a community mental health agency.

- Program remains intact

  A program cannot be considered eligible for transfer if its operational integrity were to be compromised once it divests. Non-bedded programs that rely on service agreements, staffing privileges and/or other elements that combine to make the service successful for clients must be maintained. Disruption to service must be avoided and continuity of care for clients must be preserved.

- Receiving agency demonstrates capacity

  Potential receiving organizations need to have demonstrated capacity, both programmatically and administratively, in order to be eligible to accept divested programs.

- Similarity of business between sending and receiving organizations

  Community agencies interested in accepting non-bedded programs from divested hospitals should have compatible programs in their current service spectrum. Programs under consideration for transfer to community agencies should be consistent with the receiving organization's primary mandate and purpose.

- Ability to achieve fidelity with program standards

  Provincial program standards exist in non-bedded services such as ACT teams, crisis response and case management. These standards set expectations for program requirements across the province so that they are delivered uniformly and incorporate evidence-based practices. Research has shown that fidelity to program standards demonstrates positive clinical outcomes for clients. Potential receiving organizations must demonstrate their ability to achieve fidelity to existing program standards for non-bedded programs.

- 'Culture' of receiving agency is a good program fit

  This criterion simply describes the obvious point that an agency in negotiations with a divested hospital for Tier 3 transfer must be a suitable environment for the receiving program. For example, a concurrent disorder program with a harm reduction philosophy would not be well suited for transfer to a community agency that uniformly endorses an abstinence model.

- Critical mass: achieves economy of scale

  The expertise associated with a non-bedded program, whether due to its staffing mix alone, or as a result of the relationships formed with other partners in the health care system should be maintained to continue to meet service volumes and enhance the community sector's capacity to specialize and build competency.

- Reduces duplication

  A program that is already offered by community agencies to the same extent as provided by hospitals should divest, particularly in cases where common program standards ensure consistency of care and equivalent clinical expertise.

- Preserves accessibility and brings services closer to home

  A Tier 3 transfer from hospital to community agency should improve access for clients by making services available in their home communities.

- Does not disrupt integration of other programs or reduce continuity of care

  Program transfers should improve the overall integration of services and enhance seamless delivery of services to individuals who frequently receive support from a wide variety of providers.

- Program can be delivered more effectively elsewhere

  Certain programs like vocational services make more sense to be managed and delivered by community agencies, where they have demonstrated expertise. Similarly, a program should transfer when it provides greater potential to improve an individual's quality of life (i.e., through employment training or supportive housing) and encourages his or her integration within the community.

- Evidence-based

  All Tier 3 transfers should be consistent with evidence-based models of care.

- Wellness-focused philosophy

  A program should transfer if the receiving environment is one that helps to normalize an individual's recovery experience by promoting wellness in a community setting. Further, individuals with serious mental illness, like the rest of the population, also have primary care needs, regardless of whether they experience symptoms associated with their mental illness. However, it is optimal for primary care providers to be linked with non-bedded program staff so that there is a comprehensive and consistent approach to the provision of health care to clients.

- Reduces pressure on hospital

  Tier 3 program transfers may enable individuals with mental illness to be effectively cared for in their home environment, with less reliance on hospital emergency departments for their primary care needs.

- Strengthens integration, including community/hospital linkages, service expectations, accountability and volumes

  Potential receiving organizations that can offer improvements to program efficiencies, demonstrate the same or better outcomes, and can integrate the transferred program with other health care initiatives, are preferable candidates to receive Tier 3 transfers.

- **Tier 3 transfer does not automatically denote a change in a program or its physical location**

  Despite non-bedded programs being eligible for Tier 3 transfer, it may still make sense for some programs to remain physically located in a hospital. For example, a community-sponsored crisis team may continue to be located in a hospital where the community crisis team can work closely with the hospital's emergency department personnel to divert individuals who do not need acute care. This criterion focuses on successful working relationships between hospital and community agency staff that preserve continuity of care for individuals, which improves system integration overall.

- **Supports continuum of care**

  A program could be considered eligible to transfer to a community agency if it relies on close collaboration with other partners in primary, acute and tertiary care so that clients' total health care needs are addressed.

- **Maintains clinical coherence**

  Some non-bedded programs make sense to remain with hospital sponsorship. For instance, time-limited outpatient clinics that serve as immediate bridges from inpatient to community care for specialized support are crucial to preserving a client's continuity of care because they create a natural step-down or "flow-through" to other areas of the mental health sector.

- **Promotes client needs and benefits**

  Programs that have the flexibility and management structures geared to operating preferences that are based on the individual needs of clients, rather than organizational or provider benefits, are better candidates for Tier 3 transfer.

- **Able to provide 24-hour response if part of program requirement**

  Many non-bedded programs like crisis response or safe-bed services have round-the-clock accessibility expectations. Potential receiving organizations must be able to provide the same access to care in order to maintain the integrity of a transferred program.

- **Maintains formalized protocols for admission and discharge arrangements**

  Non-bedded programs such as ACT teams adhere to provincial standards that dictate protocols for the admission and discharge of clients. When applicable, programs that are being considered eligible for Tier 3 transfer must have formalized procedures for admission and discharge to ensure that the continuity of care for clients is preserved.

- **Proximity of supervision**

  If a program requires formal supervision by staff who are not located in the same physical space as the program itself, or if required supervisors are only available at one fixed site, then the program is best suited to the environment where supervision is most accessible.

- **Change Opportunity**

  The organization and delivery of health services are dynamic and evolving. Change opportunities may present themselves and serve as catalysts for initiating Tier 3 divestment.

Moving Forward

The Tier 3 Provincial Working Group was an opportunity to unite individuals from the acute care, specialty hospital and community mental health service sectors to develop principles and share advice on common systemic, programmatic, and funding matters associated with Tier 3 transfers. Throughout its mandate, the group succeeded in clarifying provincial direction on the significance of integration, flexibility and an individual-focused philosophy of care as principles that will help meet the varied needs of diverse regions across Ontario as health care continues to evolve.

Ontario's health care landscape is changing to an environment where Local Health Integration Networks (LHINs) will be responsible for planning, integrating and funding local health services in all geographic areas of the province, so it is essential to involve them in the next steps of this process. LHINs are intended to be responsible for health services that are delivered in hospitals, long-term care facilities, community health centres, community support services and mental health agencies. They are based on the principle that community-based care is best when planned, co-ordinated and funded in an integrated manner within the local community because local residents and providers are best able to determine their own health care needs and priorities. This principle makes LHINs ideal candidates to take the lead on initiating discussions at the local level to negotiate Tier 3 transfers.

While LHINs may be ideal entities for initiating discussion about Tier 3 transfers, this statement does not suggest that all dialogue regarding Tier 3 divestment must start at the LHIN level. The impetus for discussing Tier 3 transfers can feasibly come from a number of different settings (e.g., hospitals, community agencies, local planning tables, etc.).

The principles developed specifically for Tier 3 divestment have the potential to be applied more broadly to the planning stages of any program transfer; however, this report is concerned solely with non-bedded service transfers.

The principles of Tier 3 divestment envision a mental health system that includes both hospitals and community agencies, where integration of the whole system considers all the determinants of an individual's health, regardless of where programs are located or what type of organization administers them. The principles recommended in this report encourage discussion about divestment between local parties at the earliest stages of planning. These principles are meant to guide the process, enable the parties to focus on their task and make the divestment process more manageable.

In conclusion, the principles, operational definitions and criteria in this report represent a united effort by providers and administrators who collaborated to achieve a shared vision of working systemically to invest in community services that support the entire mental health system and result in the best possible outcomes for clients.

List of Contributors

Carrie Hayward, Chair

Carrie Hayward was the Chair of the Tier 3 Provincial Working Group, and is the Director of the Mental Health and Addiction Branch responsible for community mental health programs, addiction initiatives and supportive housing. The Branch is responsible for major investments in community health including expansion of case management, ACT teams, crisis and early intervention in psychosis programs as well as a new initiative to help keep people with mental illness out of the criminal justice system. She brings extensive senior management experience in program and policy development to this portfolio from both within and outside of government.

Prior to rejoining the Ministry of Health and Long-Term Care (MOHLTC), Carrie was responsible for developing national injury prevention programs at SMARTRISK focussed on children, youth and seniors. During her previous tenure with the MOHLTC, she was responsible for initiatives related to patients' rights, community care access centres, expansion of MRI and telemedicine networks, Telehealth Ontario and population health strategies such as asthma, osteoporosis and Aboriginal Healing and Wellness. She has an Honours degree in Environmental Studies from the School of Urban and Regional Planning at the University of Waterloo.

Nancy Cornwell

Nancy Cornwell is currently a program manager in Sudbury for the North Region Branch of the Ministry of Health and Long-Term Care. Her portfolio includes the lead for all community mental health and addictions programs in the north region, as well as the specialty psychiatric hospital and the two divested Provincial Psychiatric Hospitals in the region.

Nancy's geographic assignment comprises the districts of Nipissing, Timiskaming, Muskoka and Parry Sound, and includes their general hospitals, all long-term care programs and facilities, and Community Care Access Centres. She has been an active participant in the divestment process of the North Bay Psychiatric Hospital and Lakehead Psychiatric Hospital.

Prior to working for the Ministry of Health and Long-Term Care, Nancy was Associate Administrator for North Bay Psychiatric Hospital. Her administrative experience along the continuum of mental health and addictions programs, as well as her firsthand appreciation of the divestment process make Nancy a knowledgeable contributor to the Tier 3 Provincial Working Group.

Robert E. Cunningham

Robert Cunningham is the President and Chief Executive Officer of the Northeast Mental Health Centre and is based in North Bay. Mr. Cunningham is a certified member of the Canadian College of Health Service Executives. He has an extensive background in the mental health sector, with senior leadership experience in providing specialized, acute and community services.

Prior to his current position, Mr. Cunningham was CEO of Mental Health Services-Hastings Prince Edward where he merged together staff and services from three agencies to create a comprehensive community mental health organization. Previously, Mr. Cunningham was the Administrator of the St Thomas and London Provincial Psychiatric Hospitals, starting in 1986 and extending through the HSRC directed transfer of governance to St. Joseph's Health Care. He also has formal experience with health planning as the founding Executive Director of the Haldimand-Norfolk District Health Council from 1982 to 1986.

Winnie Doyle

Winnie Doyle is the Integrated Vice President of Mental Health and Addictions Program for St. Joseph's Healthcare Hamilton and Hamilton Health Sciences Centre. She is also the Vice President of Rehabilitation and Complex Continuing Care Programs and Chief Nursing Executive of St. Joseph's.

Winnie received her Master of Nursing Administration from the University of Toronto in 2000. She has been working in Mental Health for twenty years, first as a front-line staff member, then as a nurse clinician, a nurse manager/educator and then the Director of Nursing for the Centre for Mountain Health Services of St. Joseph's Healthcare Hamilton.

She is responsible for the administration of the Mental Health Program for all three campuses of St. Joseph's Healthcare Hamilton and Hamilton Health Sciences Corporation with an annual fiscal budget in excess of $60M.

Winnie led the integration of the hospital-based mental health programs in Hamilton, and the co-ordination of the transfer of acute mental health beds from Hamilton Health Sciences to St. Joseph's Healthcare Hamilton. She spearheaded the redevelopment of the Centre for Mountain Health Services facility to accommodate 202 beds; aided in the development of the Medium Secure Forensics Unit at the Centre for Mountain Health Services; and facilitated the development of the Psychiatric Mental Health Nursing Practice Certificate Program, in conjunction with McMaster University's, School of Nursing.

Amy S. Herskowitz, Secretary

Amy S. Herskowitz was the Secretary of the Tier 3 Provincial Working Group and authored the final report with editorial assistance from the group. She is a senior program analyst in the Mental Health Program area of the Ministry of Health and Long-Term Care. Amy has worked for the Ontario government for the last five years in the Ministries of Health and Long-Term Care, and Children and Youth Services, with a focus on primary care reform, mental health reform and mental health policy and operational issues for children, youth and adults.

Outside of the public service, Amy is a self-employed health educator and consultant who specializes in the awareness and prevention of eating disorders and self-harming behaviours. Having worked as a front line service provider in crisis intervention and health promotion at Toronto General Hospital, she continues to facilitate a free weekly support group for women in York Region who struggle with disordered eating and other forms of self-harm. She designs and delivers creative, interactive workshops and presentations to clinicians, educators and students on issues of weight and body pre-occupation, healthy lifestyles and the female athlete triad. She is involved extensively in the eating disorder treatment, research and advocacy communities in Toronto, and on a national level. She received her Hons. BA in English and Medical Sociology from the University of Western Ontario in 1996, and her M.Sc. in pathophysiology and sport psychology from the University of Toronto in 2002.

Pamela Hines

Pamela Hines, M.S.W., is the Chief Executive Officer for the Canadian Mental Health Association, Windsor-Essex County Branch and has been in this position for 18 years. During that time she has participated on numerous provincial committees.

The Branch is the primary provider of community mental health services for Windsor-Essex and received a three-year accreditation with the Canadian Council on Health Services Accreditation in August 2005.

Services provided by the Branch for people having a serious mental illness include:

- Intensive case management with specialized services in justice, early intervention, CTO and the mental health program for older adults.
- Supported housing, 24 hour high support, group homes and safe beds
- Vocational and employment services

The Branch has been a leader in the integration of mental health services and primary care and was recently approved as a satellite community health centre. The Branch is also one of four partners incorporating for the Family Health Team recently approved in Leamington.

Pam's prior related work experience includes seven years with the Ministry of Community and Social Services as a program supervisor in the tri-county area of Essex, Lambton and Kent, and five years with the Roman Catholic Children's Aid Society.

Cliff Nordal

St. Joseph's Health Care (London) President and Chief Executive Officer, Cliff Nordal earned a Masters degree in Business Administration at York University, and a Bachelor of Science degree in Physics at the University of North Dakota. A past Chair and Fellow of the Canadian College of Health Service Executives, Cliff is also active in a number of provincial and national associations. He currently serves on the Ministry of Health and Long Term Care's Ontario Hospital Association Hospital Report Strategic Advisory Committee, and on the Boards of the Lawson Health Research Institute and the New St. Joseph's Health Care Foundation.

Effective January 1, 2006, Cliff assumed his new appointment as President and Chief Executive Officer of London Health Sciences Centre, in addition to his role at St. Joseph's Health Care, London. Cliff is also a member of the boards of the Council of Academic Hospitals of Ontario and the Catholic Health Association of Ontario.

Don Palmer

Don has been the Executive Director of Causeway Work Centre, a community mental health agency serving eastern Ontario, since 1992. Causeway currently operates a pre-vocational training and supported employment program that incorporates a variety of best practice and community employment approaches. Until 2005, Causeway was one of 13 Ministry-funded clubhouse programs in the province of Ontario and was the only clubhouse in eastern Ontario. Causeway was a member of the International Center for Clubhouse Development and achieved the highest level of certification granted by that association.

Don has 30 years of experience in the field of Human Services and business management. His experience is very broad based, managing programs and providing direct services to persons with a variety of disabilities.

Don sits on the Community Relations Committee for the Centre for Addictions and Mental Health. He was appointed by the Minister of Health to the Community Advisory Board of Brockville Psychiatric Hospital, and served on the board for a period of five years until governance was transferred to the Royal Ottawa Health Care Group. Don was appointed to the Ministry's Provincial Advisory Council that developed Ontario's policy on employment supports to persons with serious mental illness, entitled "*Making It Work*". He was also appointed by the Ministry of Health and Long-Term Care to the Advisory Council of the Ontario Council of Alternative Businesses. He was appointed to the Champlain District Mental Health Implementation Task Force (MHITF) and was responsible for writing the section of the MHITF report that related to employment and education.

Judy Shanks

Judy Shanks is the Chief Executive Officer of the Canadian Mental Health Association Cochrane-Timiskaming Branch (CMHA-CT), an organization that has a capital and operating budget of more than $17 million with a staff complement of more than 125 people.

The CMHA-CT Branch serves rural communities with populations from 1,500 to 50,000 from Timmins to Timiskaming Shores, covering a geographic area of over 100,000 square kilometres.

Judy has always been a strong advocate for Northern Ontario and has worked avidly for the North. She has extensive years of experience in the community mental health field. The Branch has two ACT teams, case management, community support, residential housing, family violence and public education, as well as court diversion, dual diagnosis. The Branch has moved progressively through these changing times, making the agency an integral part of all the communities it is serving.

Judy was a member of the Northeast Mental Health Implementation Task Force, completed a two-year term with the Ministry's Provincial Advisory Committee on Mental Health Reform, was vice chair of the Cochrane District Health Council, chaired the CMHA Ontario Division Executive Directors' Network, and chaired the CMHA Ontario Division's Mental Health Reform Committee. She currently chairs the Complaints Committee for the Ontario College of Social Workers & Social Service Workers and continues to be involved on various Mental Health Committees throughout the province and is a mentor for many colleagues.

Bruce H. Swan

Bruce Swan is the President and Chief Executive Officer of the Royal Ottawa Health Care Group.

A Fellow of the Canadian College of Health Service Executives, Bruce has the vision and leadership key to achieving a client-focused health care system that promotes efficiency, integration and collaboration. He holds a graduate diploma in Hospital Administration from the University of Toronto and a Bachelor of Commerce degree from Queen's University.

Previously, Bruce was Executive Director of Mental Health for the Calgary Health Region, where he worked to improve administrative efficiencies and patient outcomes of a mental health system to which the ROH is evolving. Bruce also brings more than 10 years of experience as an accreditation surveyor for the Canadian Council on Health Services Accreditation, which evaluates compliance with standards in health care delivery.

In all, Bruce has more than 27 years of direct experience in senior positions in a number of health care organizations across Canada, especially in the western provinces. He is particularly skilled in strategic planning and organizational renewal, employing a philosophy that values input from all stakeholders.

Bruce is dedicated to consensus building and the effective integration of community health services. He believes in fostering a positive, interactive work environment using the spirit of co-operation to implement positive change.

Brent Woodford

Brent is currently the Executive Director of Adult Mental Health Services of Haldimand-Norfolk, a rural/remote community mental health agency providing counselling and treatment, CTO Case Management, Specialized Geriatric Services, mental health telephone crisis assessment and support and a consumer/survivor Resource Centre.

Previously, Brent was Executive Director of Fort Smith's Department of Health and Social Services for the Government of Northwest Territories, where he was responsible for all health and social services in the Fort Smith area.

Brent has a Masters degree in Health Sciences (Administration) and is a Certified Health Executive. His outside interests include program evaluation and effectiveness.

Special thanks:

Marc Piquette

Marc Piquette served on the Tier 3 Provincial Working Group prior to Bob Cunningham's appointment as President and Chief Executive Officer at the Northeast Mental Health Centre. He is a lawyer, member of the Law Society of Upper Canada and has a Masters of Business Administration degree.

Marc possesses over 10 years of senior management health care experience. Prior positions have included the position of Executive Director, Corporate Services with the NEMHC, and Director of Employee Relations with the Sudbury Regional Hospital. Prior to joining the health care system Marc was an Associate Lawyer with a law firm that restricted its practice to labour, employment and organizational human resources matters.

Marc has served on a number of provincial health care committees including, the Ontario Hospital Association Provincial Health Human Resources Strategic Advisory Group, Hospital Report Research Collaborative Mental Health Report Advisory Panel, Ontario Hospital Association Provincial Psychiatric Hospital Divestment Committee and Ontario Hospital Association Central Negotiation Team – C.U.P.E. He has also been appointed by the Ontario Council of Regents for Colleges of Applied Arts and Technology as a nominee on arbitration boards.

Alternates

Alternates of the Tier 3 Provincial Working Group functioned as substitutes for original members who were not able to attend individual meetings. Their participation in this process was indispensable and maintained continuity for the working group. The contributions of alternates were tremendously important and equally valuable to the preparation of this final report.

Kathleen A. Fyfe, CA

Ms. Fyfe is an experienced senior manager currently employed as Interim Executive Director Corporate Services of the Northeast Mental Health Centre (NEMHC).

Ms. Fyfe has provided strong leadership for Northeast Mental Health Centre on the transfer of North Bay Psychiatric Hospital to NEMHC in November 2005, the development of the new joint hospital project – the North Bay Regional Health Care Centre and the local program transfer of district and community programs.

Peter Szota

Peter is currently administrative director at St. Joseph's Healthcare Hamilton with prime responsibilities within the divested provincial psychiatric hospital. System development, Divestment Planning, Recovery, and Peer Initiatives have been areas of focus. Peter has over 20 years of senior health care management experience including mental health leadership roles in teaching hospitals, community hospitals and community mental health agencies. He was previously the Executive Director of a Community Mental Health Agency and Administrator of a Children's Mental Health Centre.

Sandy Whittall

Sandy is currently the Integrated Vice President of Mental Health Programs for both St. Joseph's Health Care, London and London Health Sciences Centre. Between 1999 and 2002, Sandy was the first Integrated Vice President of Strategic Alliances and Networks (ISAN) for both London hospitals. In that capacity, she and the ISAN team led numerous regional initiatives and enabled the London hospitals to foster positive, effective relationships with regional hospitals, community care partners, and Ministry representatives.

Prior to this, Sandy worked for the London Health Sciences Centre holding a variety of administrative and nursing leadership positions.

References

Canadian Council on Health Services Accreditation. (2002). *Achieving Improved Measurement Standards*, Second Edition.

Forensic Mental Health Services Expert Advisory Panel. (December, 2002). *Assessment, Treatment and Community Re-Integration of the Mentally Disordered Offender, Final Report*. Submitted to the Ontario Ministry of Health and Long-Term Care. Available online: www.health.gov.on.ca/english/providers/pub/mhitf/forensic_panel/final_report.pdf

Health Services Restructuring Commission. (March, 2000). *Looking Back, Looking Forward: Seven Points for Action*. Submitted to the Ministry of Health and Long-Term Care. Available online: www.health.gov.on.ca/hsrc/Seven.doc.

Health Services Restructuring Commission. (March, 2000). *Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission (1996-2000). A Legacy Report*. Submitted to the Ministry of Health and Long-Term Care. Available online: www.health.gov.on.ca/hsrc/HSRC.pdf.

Health Reform Implementation Team. (February, 2003). *Planning Principles for Post Tier 1 Divestment of Psychiatric Beds and Services*. Ontario Ministry of Health and Long-Term Care. Available online: www.health.gov.on.ca/english/providers/program/mentalhealth/mohtier3/tier3_pab/tier1_planning_principles.pdf.

Provincial Forum of Mental Health Implementation Task Force Chairs. (December, 2002). *The Time Is Now: Themes and Recommendations for Mental Health Reform in Ontario*. Submitted to the Ontario Ministry of Health and Long-Term Care. Available online: www.health.gov.on.ca/english/providers/pub/mhitf/provincial_forum/provincial_forum.pdf.

White, K. W. (Facilitator). (August, 2005). *Final Report on the Transfer of District and Local Mental Health & Addictions Program in Northeastern Ontario*. Submitted to the Minister of Health and Long-Term Care for Ontario.

Appendix

Glossary of Terms

Academic Health Science Centres (AHSC): An alliance between:

- A university with a faculty of health sciences or a school of medicine,
- A fully affiliated teaching hospital(s), and
- Medical staff who hold both privileges at the teaching hospital and an academic appointment from the university.

Academic Health Science Centres are both referral centres and centres of excellence in specialized clinical services; they teach medical students and conduct medical research.

Acute Care: Short-term medical treatment that usually takes place in hospital, for patients with a rapid onset of illness, injury, or recovering from surgery.

Mental Health Reform: In 1998, the Ontario government set in motion a plan to reform Ontario's mental health system. The government listened to key stakeholders – including consumers, their families and service providers - about changing the way mental health services are delivered. Through mental health reform, the Ministry of Health and Long-Term Care is shifting to a flexible, co-ordinated and accountable system of community-based services to deliver needed services and support to those with serious mental illness as close to home as possible

Tertiary Care: Highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities, and often involving high-technology resources.

Tier 1 Divestment: The process of transfer of governance and operations of a Provincial Psychiatric Hospital to a Public Hospital Board

Tier 2 Divestment: The subsequent process of transfer of psychiatric beds and associated services received by a Tier 1 receiving Public Hospital Board (from a Provincial Psychiatric Hospital) to another public hospital as directed by the Health Services Restructuring Commission.

Tier 3 Divestment: The process of transfer of former PPH programs and services to a community agency (otherwise known as community reinvestment).

Catalogue No. CHD-2240529 100 Sept./06 © Queen's Printer for Ontario

Ontario